Dr. Eddy Mydouangchanh, D.C.

MDC Chiropractic
14455 SW Allen Blvd. Suite 102
Beaverton, OR 97005
(971) 303 - 8880

Alameda Family Chiropractic
4410 NE Fremont Street
Portland, OR 97213
(503) 249 - 0114

PATIENT INFORMATION

Patient's Name_____ Today's Date_____
(Last) (First) (Middle) (Nickname)

Address_____ Zip Code_____
(Street) (City) (State)

Email Address_____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone(_____)_____

Receive appointment reminders by text? ☐ Yes ☐ No • Cell Phone Provider: _____

☐ Male ☐ Female Age_____
Birthdate_____
(Month/ Date/ Year)

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Divorced ☐ Separated ☐ Partnered for _____ years

Patient's Employer/School _____
Occupation_____

Employer/School Address_____

Spouse/Parent's Name_____
Birthdate_____

Spouse/Parent's Employer_____ Phone (_____)_____

☺ Whom may we thank for referring you?_____☺

MEDICAL

Date of last general exam_____ Primary Care Physician_____

List any allergies you have (Drug, food, Hay Fever, Other)_____

List any Medications you are taking_____

Do you have: **High Blood Pressure**? ☐ Yes ☐ No **Diabetes**? ☐ Yes ☐ No **High Cholesterol**? ☐ Yes ☐ No

Describe any conditions we should know about_____

Are you seeing the doctor because of an accident? ☐ Auto ☐ Work ☐ Home ☐ None

INSURANCE

Who is responsible for this account?_____

Primary Insurance Co._____ Policy Holder_____

ID/Claim #:_____Group/Policy #: _____Phone (_____)_____

➔ **Please provide your Insurance Card so we may take a copy of it!!**

Secondary Insurance Co._____ Policy Holder_____

ID/Claim #:_____Group/Policy #: _____Phone (_____)_____

Insurance Assignment and Release

I certify that I have Insurance coverage with

_____
Name of Insurance Company(s)

And assign directly to Dr. Eddy B. Mydouangchanh, D.C. all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

_____

Signature of patient or Parent if minor

Please print name of patient or parent if minor

_____

_____

Date of signature

Relationship to Patient

By signing this form I also understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits.

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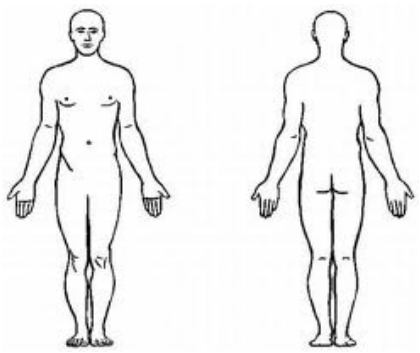
SYMPTOMS & INJURIES QUESTIONNAIRE

Patient Name:_____ Date:_____

Mark all that apply

Concussion?	❑ Yes	❑ No
Headaches?	❑ Yes	❑ No
Dizziness?	❑ Yes	❑ No
Nausea?	❑ Yes	❑ No
Loss of Balance?	❑ Yes	❑ No
Ringing in Ears?	❑ Yes	❑ No
Blurred Vision?	❑ Yes	❑ No
Loss of Memory?	❑ Yes	❑ No
Fluid in Ears?	❑ Yes	❑ No
Vomiting?	❑ Yes	❑ No
Jaw Pain?	❑ Yes	❑ No
Eating Difficulty?	❑ Yes	❑ No
Chewing Difficulty?	❑ Yes	❑ No
Neck Pain?	❑ Yes	❑ No
Shoulder Pain?	❑ Yes	❑ No
Back Pain?	❑ Yes	❑ No
Hip Pain?	❑ Yes	❑ No
Numbness or Tingling in the arms/hands/fingers?	❑ Yes	❑ No ❑ Right ❑ Left
Numbness or Tingling in the legs and/or feet?	❑ Yes	❑ No ❑ Right ❑ Left

☆Please **CIRCLE** the areas of complaint. Indicate with the appropriate symbol the nature of your symptom*(s)*



Dull/ Achy Pain ~ ZZZ
Numbness ~ XXX
Burning Pain ~ BBB
Shooting Pain ~ ↯ ↯
Swelling ~ SSS
Tingling ~ ===
Throbbing ~ vvv

IMPAIRED ACTIVITIES (Circle those that apply)

Sports	Aerobic Exercise	Archery	Backpacking	Bowling
Badminton	Baseball	Basketball	Basketry	Bicycling
Boxing	Card Playing	Camping	Dancing	Fencing
Fishing	Flying	Football	Gardening	Golf
Handball	Gymnastics	Health Clubs	Hockey	Hunting
Judo	Horseback Riding	Ice Skating	Karate	Painting
Pottery	Jogging/Running	Photography	Racquetball	Rafting
Yoga	Mountain Climbing	Snow Skiing	Sailing	Tennis
Soccer	Rowing/Boating	Softball	Water Skiing	Swimming
Walking	Musical Instruments	Volleyball	Weight Lifting	

DAY TO DAY ACTIVITIES (Circle those that apply)

Dressing	Bathing/Showering	Bending	Brushing Teeth	Cooking
Holidays	Dining Out	Ironing	House Cleaning	Movie Going
Laundry	Sexual Relations	Lifting	Church Events	Crafting
Moving	Shampooing Hair	Reading	Shaving	Shopping
Sitting	Watching TV	Sleeping	Social Events	Standing
Traveling	Car Washing	Vacations	Yard Work	Child Care

WORK-RELATED ACTIVITIES (Circle those that apply)

Sitting	Standing	Telephoning	Computer Work	Lifting
Reading	Bending	Typing	Writing	

Continued On Reverse Side
➔➔➔➔➔➔

HEALTH HISTORY (Mark those that apply)

Past	Current		Past	Current		Past	Current	
❑	❑	Allergies	❑	❑	Goiter	❑	❑	Pleurisy
❑	❑	Appendicitis	❑	❑	Heart Attack	❑	❑	Pneumonia
❑	❑	Arthritis	❑	❑	Hepatitis (HAV, HBV, HCV)	❑	❑	Polio
❑	❑	Asthma	❑	❑	Herpes	❑	❑	Rheumatic Fever
❑	❑	Cancer	❑	❑	Scarlet Fever	❑	❑	Smallpox
❑	❑	Chickenpox	❑	❑	Influenza	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Kidney Disease	❑	❑	Tuberculosis
❑	❑	Diphtheria	❑	❑	Lumbago	❑	❑	Urinary Tract Infection
❑	❑	Eczema	❑	❑	Malaria	❑	❑	Thyroid Disease
❑	❑	Emphysema	❑	❑	Measles	❑	❑	Whooping Cough
❑	❑	Epilepsy	❑	❑	Mumps	❑	❑	Typhoid Fever

List all surgeries you have had (Chronologically)

_____Month/Year_____Physician_____City_____

_____Month/Year_____Physician_____City_____

_____Month/Year_____Physician_____City_____

_____Month/Year_____Physician_____City_____

Remarks:_____

List ALL serious accidents & injuries that you have had

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

Remarks:_____

List any fractures, dislocations, or concussions that you have had

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

_____Month/Year_____Hospitalized? ❑ Yes ❑ No

Remarks:_____

List ALL medications and/or supplements that you are currently taking

_____Frequency_____Prescribed By:_____Month/Year_____

_____Frequency_____Prescribed By:_____Month/Year_____

_____Frequency_____Prescribed By:_____Month/Year_____

_____Frequency_____Prescribed By:_____Month/Year_____

Remarks:_____

PREVIOUS CHIROPRACTIC CARE ❑ None ❑ Occasional ❑ Frequent

Name of Chiropractor_____Dates_____/_____ to _____/_____City_____

Name of Chiropractor_____Dates_____/_____ to _____/_____City_____

Remarks:_____

X-RAY EXPOSURE (*EXCLUDING Dental or Chest X-Rays)*

❑ None ❑ Few ❑ Several ❑ Many

FAMILY HISTORY Please list any pertinent family health conditions (grandparents, parents, siblings) Dr. Eddy Should know about:

_____

_____

_____

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HIPAA OMNIBUS NOTICE of PRIVACY PRACTICES

(Revised 2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAITON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc.., to ensure that the healthcare provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a specific procedure, therapy, DME, or nutritional supplies, etc…, may require that your relevant protected health information be disclosed to the health plan to obtain approval for payment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as needed, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES ABD DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to abject unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.
You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and request a copy of your protected health information *(fees may apply)* – Pursuant to your written request, you have the tight to inspect or request a copy of your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or obtain a copy of the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.
You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare which you have paid in full out of pocket.
You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively *(i.e. electronically)*.
You have the right to request an amendment to your protected health information – If we deny your request for amendment; you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: Pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six (6) years prior to the date of request.
You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice of you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your physician or office manager of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please contact our office and we will be happy to assist you.

Also, please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Signature of patient *(or Parent if minor)* | Please print name of patient *(or parent if minor)*

_____ _____

Date of signature | Relationship to Patient

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Patient Confidentially Questionnaire

Please list any family members or other persons whom we may contact in case of an emergency or discuss your general condition & diagnosis *(including treatment, payment, appointments & health care operations)*:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Please print the telephone number you prefer to receive calls about appointments or any other health care information:
PLEASE NOTE: I am fully aware that a cell phone is not a secure and private line.

_____

Can confidential messages *(such as appointment reminders)* be left on your telephone answering machine or voicemail?

❑ YES ❑ NO

Please print the address where you would like your billing statements and/or correspondence from our office to be sent:

Address:_____

City:_____ State:_____ Zip:_____

Please indicate if you would like all correspondence from our office sent to you in a sealed envelope marked "CONFIDENTIAL"

❑ YES ❑ NO

_____ _____
Signature of Patient *(or Parent if minor)* Please Print Name of Patient *(or parent if minor)*

_____ _____
Date of Signature Relationship to Patient

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Informed Consent To Chiropractic Treatment

Patient Name: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of chiropractic treatment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctor will use that procedure to treat you. The doctor may use his hands or a mechanical instrument upon your body in such a way to move your joints. The doctor will use his hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel a sense of movement in the joint.

Analysis / Examination / Treatment:

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

_____ Spinal Manipulative Therapy	_____ Palpation	_____ Vital Signs
_____ Range of Motion Testing	_____ Orthopedic Testing	_____ Basic Neurological Testing
_____ Muscle Strength Testing	_____ Postural Analysis Testing	_____ Ultrasound Therapy
_____ Hot/Cold Therapy	_____ Electrical Muscle Stimulation	_____ Soft-Tissue Massage Therapy
_____ Cupping	_____ Mechanical Traction	_____ Hydro-Massage Therapy
_____KT Taping/Strapping	_____ Other: _____	

*****Patient should initial each procedure they are consenting to*****

Possible Risks:

As with any health care procedure, there are certain complications which may arise during chiropractic manipulation and therapy. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. Complications from chiropractic treatments could include but are not limited to: fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

****The doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.**

Probability of risks occurring:

The risks of complications due to chiropractic treatments have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. Fractures are rare occurrences and generally result from some underlying weakness of the bone which the doctor will check for during the taking of your history and during examination. The doctor may refer you to have X-Ray's taken if concern arises during your examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to the specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk for arterial stroke.

The availability and nature of other treatment options:

Other treatment for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

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If you chose to use one of the above noted “other treatment” options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Continued on Reverse Side
➔➔➔➔➔➔➔

Risks of remaining untreated:
Remaining untreated or the delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult and/or less effective.

Informed Consent To Chiropractic Treatment (MINOR)

I hereby request and authorize Dr. Eddy Mydouangchanh, DC to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination and/or referral at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

Please check the appropriate box and sign below:

❒ **I have read the above explanation of the chiropractic adjustment and related treatments MYSELF.**

❒ **The above explanation of chiropractic adjustment and related treatments was READ TO ME.**

I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. Having been informed of the risks, I have freely decided to undergo the recommended treatment and herby give my full consent to treatment with Dr. Eddy Mydouangchanh. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the recommended treatment.

_____ _____

Signature of patient or Parent if minor | Please print name of patient or parent if minor

_____ _____

Date of signature | Relationship to Patient

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Dr. Eddy's Office Policies

☺ Thank you for choosing Dr. Eddy for your healthcare needs ☺

Payment and Insurance:
Payment is expected at the time of service unless other arrangements have been made prior to your appointment. This applies to insurance copays and deductibles.

Private Health Insurance:
As a courtesy to you, we are happy to submit bills to your health insurance company on your behalf. We will make every effort to obtain reimbursement from your insurance company. However, YOU are ultimately responsible for the cost of treatment that is not covered or denied by your insurance.

Motor Vehicle Collisions and Workers Compensation
If you have been injured in a motor vehicle collision or on the job, we will bill YOUR auto or workers compensation insurance. If you are represented by an attorney, s/he will be provided with duplicate copies of all documents sent to your insurance.

It is important to understand that while PIP or Work Comp insurance generally covers all expenses for your treatment, you are ultimately responsible for any unpaid balance from a denied expense/charge.

It is not uncommon for Auto or Work Comp insurance payments to be delayed, often up to 60 days or longer after receipt of billing from our office. With that said; any unpaid balance that extends beyond 60 days may be subject to a monthly finance charge of 1.5% interest.

Appointments, Cancellations & Returned Checks:
In order to accommodate the needs of other patients, we require a 24 hour notice of cancellation. Please be respectful of this policy. While some circumstances are certainly understandable and unavoidable, we reserve the right to charge $35.00 for missed appointments, as well as, checks that are returned because of insufficient funds. Any charges that our bank applies to such a transaction will also be your responsibility.

I have read and understand the above office policies:

_____ _____
Signature of patient or Parent if minor | Please print name of patient or parent if minor

_____ _____
Date of signature | Relationship to Patient

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IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT OF RECOVERY

In consideration and exchange for not having to immediately pay a debt owed; and in consideration for receiving future care by Dr. Eddy Mydouangchanh upon whose letterhead this document is printed, I, the undersigned, hereby assign and convey to Dr. Mydouangchanh a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the **____ day of _____, 20___,** to the full extent of the cost and treatment provided or to be provided to me by Dr. Mydouangchanh.

I hereby authorize and direct my attorney(s) to hold in trust and to pay directly to Dr. Eddy Mydouangchanh such sums as may be due and owing her for treatment and other professional services rendered me both by reason of this accident and by reason of any other bills that are due to Dr. Mydouangchanh; and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect Dr. Mydouangchanh. I hereby further give, grant and convey a lien on my case to Dr. Mydouangchanh against any and all proceeds of any and all causes of action, settlements, judgments or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by Dr. Mydouangchanh.

I fully understand that I am directly and fully responsible to Dr. Eddy Mydouangchanh for all charges incurred for services rendered me and that this agreement is made solely for Dr. Mydouangchanh's additional protection and in consideration for Dr. Mydouangchanh's waiting for payment. I further understand that payment for services rendered by Dr. Mydouangchanh is not contingent on any settlement, judgment or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand if my attorney*(s)* does/do not protect Dr. Eddy Mydouangchanh's interest, he may require me to make payments on a regular current basis. Dr. Mydouangchanh may also bring a cause of action against my attorney*(s)* for failing to honor this binding and irrevocable lien agreement between myself and Dr. Eddy Mydouangchanh.

I further understand and agree that Dr. Eddy Mydouangchanh is not responsible for paying any of my attorney's fees and he does not agree to pay my attorney*(s)* and/or attorney fees for honoring this agreement between myself and Dr. Eddy Mydouangchanh.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY*(S)* TO PROTECT DR. EDDY B. MYDOUANGCHANH'S INTEREST AT THE TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO DR. EDDY B. MYDOUANGCHANH. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM DR. EDDY B. MYDOUANGCHANH. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT OF PAYMENT AND LIEN."

_____ _____
Signature of patient or Parent if minor | Please print name of patient or parent if minor

_____ _____
Date of signature | Relationship to Patient

Dr. Eddy B. Mydouangchanh, D.C.
Chiropractic Physician
4410 NE Fremont Street
Portland, OR 97213

WORKER'S COMPENSATION INJURY DATA

Patient Name:_____ Today's Date:_____

Date of Accident:_____ Time accident occurred:_____ ❑ AM / ❑ PM

Who is your Employer?:_____ Occupation:_____

Describe how your injury occurred:_____

_____

Was anyone else present during your accident? ❑ Yes ❑ No

If yes, Who?:_____

Have you reported this to your employer? ❑ Yes ❑ No

If yes, when did you report you injury *(approximately)*?_____

Name of person you reported the injury to:_____

Check the symptoms apparent *SINCE* the accident:

❑ Headache	❑ Loss of smell	❑ Numbness in arms/fingers
❑ Neck pain/stiffness	❑ Loss of taste	❑ Numbness in legs/feet
❑ Mid-back pain	❑ Loss of memory	❑ Cold hands/feet
❑ Low-back pain	❑ Loss of hearing	❑ Diarrhea
❑ Sensitive to light/sound	❑ Jaw pain/clicking	❑ Constipation
❑ Pain behind eyes	❑ Visual changes/blurring	❑ Chest pain
❑ Dizziness/lightheaded	❑ Irritability	❑ Anxious
❑ Fainting/blackouts	❑ Depression	❑ Cold sweats
❑ Ringing/buzzing ears	❑ Sleeping problems	❑ Fatigue
❑ Loss of balance	❑ Nausea/vomiting	❑ Heavy headed
❑ Loss of grip strength in hands	❑ Sore throat	❑ Difficulty swallowing
❑ Muscle soreness/pain/tenderness	❑ Frequent urination	❑ Abdominal pain
❑ Clumsiness	❑ Trouble concentrating	❑ Nervousness
❑ Shortness of breath	❑ Nightmares	❑ Tension
❑ Afraid	❑ Easily startled	❑ Other:_____

Indicate the degree of comfort while performing the following activities *(even if only sometimes)*:

Lying on your back……	❑ Comfortable	❑ Uncomfortable	❑ Painful
Lying on your side……..	❑ Comfortable	❑ Uncomfortable	❑ Painful
Lying on your stomach…….....	❑ Comfortable	❑ Uncomfortable	❑ Painful
Sitting……..	❑ Comfortable	❑ Uncomfortable	❑ Painful
Stretching……....	❑ Comfortable	❑ Uncomfortable	❑ Painful
Sexual Relations……..	❑ Comfortable	❑ Uncomfortable	❑ Painful
Walking……....	❑ Comfortable	❑ Uncomfortable	❑ Painful
Running……...	❑ Comfortable	❑ Uncomfortable	❑ Painful
Sports……...	❑ Comfortable	❑ Uncomfortable	❑ Painful
Working……...	❑ Comfortable	❑ Uncomfortable	❑ Painful
Lifting……...	❑ Comfortable	❑ Uncomfortable	❑ Painful
Bending……...	❑ Comfortable	❑ Uncomfortable	❑ Painful
Kneeling……..	❑ Comfortable	❑ Uncomfortable	❑ Painful
Pulling……	❑ Comfortable	❑ Uncomfortable	❑ Painful
Reaching……...	❑ Comfortable	❑ Uncomfortable	❑ Painful

What activities does your work require?:_____

_____

_____

Have you missed time from work? ❑ Yes ❑ No

If yes, how many days did you miss? _____

Were you released from work by a Doctor? ❑ Yes ❑ No

If yes, by what Doctor? _____

Dates of Release:_____ to _____ ❑ Part-Time off work ❑ Full-Time off work ❑ Unable to work since accident

As a result of the accident you were: ❑ Rendered Unconscious ❑ Dazed/Confused ❑ Other:_____

Were you able to move all parts of your body? ❑ Yes ❑ No

If no, what parts and why?_____

_____

Did the accident result in bleeding cuts or bruises? ❑ Yes ❑ No

If yes, where were the bleeding cuts?_____

If yes, where were the bruises?_____

Describe how you felt **IMMEDIATELY** after the accident *(Please be specific)*:_____

_____

_____

_____

Did you have pain right away? ❑ Yes ❑ No

If yes, where?_____

If no, did the pain happen: ❑ Later that day *(Approximate time)*:_____ ❑ Later that night *(Approximate time)*:_____

❑ The next day *(Approximate Date)*:_____ ❑ A few days later *(Approximate time)*:_____

Did you have any physical complaints **JUST BEFORE THE ACCIDENT?** ❑ Yes ❑ No

If yes, please describe in detail:_____

_____

_____

PRIOR to this accident, did you ever have symptoms similar to what you are experiencing now? ❑ Yes ❑ No

If yes, please explain *(briefly include past falls/injuries/accidents/surgeries/etc):*_____

_____

_____

Do you notice any activities of your daily home or work routine that is different **NOW** than from **BEFORE** the accident? ❑ Yes ❑ No

Those you are UNABLE to do:_____

Those that are PAINFUL to do:_____

Those that are DIFFICULT to do:_____

Did you seek medical help immediately or soon after the accident? ❑ Yes ❑ No

If yes, how did you get there? ❑ Someone else drove me ❑ Ambulance

❑ Drove my own car ❑ Police

❑ Other:_____

Doctor #1 / Hospital and or Clinic Seen:_____ **Date Seen:**_____

Were you examined? ❑ Yes ❑ No

Were X-Rays Taken? ❑ Yes ❑ No

Did you receive treatment? ❑ Yes ❑ No

If yes, what treatment was provided to you? ❑ Bed Rest ❑ Brace ❑ Physiotherapy ❑ Adjustments ❑ Medications ❑ Other:_____

What benefits did you receive from the treatment(s)? _____

Date of Last Treatment:_____

Doctor #2 / Hospital and or Clinic Seen:_____ **Date Seen:**_____

Were you examined? ❑ Yes ❑ No

Were X-Rays Taken? ❑ Yes ❑ No

Did you receive treatment? ❑ Yes ❑ No

If yes, what treatment was provided to you? ❑ Bed Rest ❑ Brace ❑ Physiotherapy ❑ Adjustments ❑ Medications ❑ Other:_____

What benefits did you receive from the treatment(s)? _____

Date of Last Treatment:_____

Do you have an attorney retained for this case? ❑ Yes ❑ No

Attorney's Name:_____ Firm:_____

Address:_____ City:_____ State:_____ Zip:_____

_____ _____

Signature of Patient, Parent if Minor, or Representative for Patient | Please Print Name of Patient, Parent if Minor, or Representative for Patient

_____ _____

Date of Signature | Relationship to Patient (Self, Parent, Representative, etc.)

Worker's Compensation Insurance Information

Insurance Company:_____

Address:_____ City:_____State:_____Zip:_____

Adjustor's Name:_____ Phone #:_____

Claim #:_____ Policy #:_____Policy Holder:_____

☺ Thank You! ☺